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**From *the* Editors**

## Reflections on Scholarship: Getting Started Doing Research

The Louisiana Journal of Counseling (LJC) has had since its inception the goal of promoting scholarship within the counseling profession in Louisiana. In the quest to encourage counselors to develop their personal scholarship and the scholarship of others, we often encounter as editors a hesitation and sometimes a fear of submitting scholarly manuscripts for publication. Many times that ambiguity of, “What would I write about?” or, “How would I even get started?” along with other self- doubts surface as stumbling blocks to getting started. It is hoped that the suggestions in this article, based largely on previous work of Duba (2001), will answer some of the questions that might be deterring you from considering submissions. Her article elaborates on the four functions of scholarship posed originally by Boyer (1990). The four functions are: the scholarship of discovery, the scholarship of integration, the scholarship of appreciation, and the scholarship of teaching. The editors hope that by examining these four functions of scholarship the reader will be provided with some useful starting points for their personal research efforts.

###### Scholarship of Discovery

The first function, the scholarship of discovery, is the quest to seek new knowledge to add to the body of knowledge in counseling. Upon initial reading of this function, adding

something new to all that is already out there can impose a daunting task.

However, if the reader goes back to some of the very basic principles of investigation using simple observations (Orcher, 2005), much ambiguity is lifted and starting points for research are clear. Orcher proposed six questions that can be used in many cases individually to conduct less complex research or that can be combined to get more detailed research.

1. *What is the prevalence of the observed behavior?* (p.3) Investigation almost always begins with the simple question of, “What is currently occurring?” The baseline of behavior or the prevalence of the observed behavior prior to any type of manipulation is the traditional starting point for research. The observation can be substantiated by formal means of recording such as a checklist or other types of pretests. The frequency, intensity, and duration of whatever is being observed are used to establish the baseline or prevalence which may end up being the purpose of the study, or the information may just be a starting point for a more sophisticated technique or intervention to measure effectiveness.
2. *What are the demographics of those who exhibit the behavior*? (p.3)

Observing specific descriptions of the individuals one is observing is essential for other researchers to be able to replicate the work with other populations.

Demographics that are commonly used include: age, gender, race, developmental stage, socioeconomic status, and educational level. Accurate identification of a specific population doing just about any behavior could be the entire study. Accurate demographics also allow for replication of research and experimental design adaptations.

1. *What is the cause of the observed behavior?* (p.3)

Observing and documenting the situations or stimuli that trigger the observed behaviors are a vital part of many studies.

Recording observations that can link specific precursors to specific behaviors can be instrumental in the development of studies in preventative work. A study might have the focus of linking cause and effect such as, a driver’s aggressive and erratic driving is often related to their feelings of anger. Or the study might use the casual link to expand on other connected topics. Knowing that traffic congestion facilitates anger in some drivers could be used to design preventative measures that deal with initial levels of anger. These could also be the focus of research.

1. *What does the observed behavior cause?* (p4)

Examining the impact, either immediate or long term, is often essential as behaviors or lack of behaviors observed would be far more cost effective to address than what the behavior or lack of

behavior might cause. Recent studies that link childhood inactivity to obesity in children is one of many possible examples. Increasing movement of any kind is a simple inexpensive way that research can answer a devastating health issue.

1. *Is it possible to predict the behavior?* (p4)

All of the preventative models that work, for example teaching social skills and classroom guidance, are predication upon research of identification of those who are susceptible to inappropriate behaviors. These behaviors can be modified easier than behaviors that are habitual. This type of research often combines the demographics from

#2 to identify the best predictors of certain behaviors.

1. *What theory or theories might account for that behavior*? (p4) The direct application of a theory or the comparison of the effectiveness of two or more theories to explain the behavior is essential to most research. The literature review for almost all research requires documentation from previous theories to help formulate how the new data compares to the existing body of research.

###### Scholarship of Integration

Achieving the scholarship of integration rests on the ability of the individual to accomplish a two-fold integrative process (Boyer, 1990). This process includes being able to first examine and integrate previous research within the field of counseling. Second, the researcher must be able to integrate the research into the body of research from other mental health professions. This ability becomes quite

evident in the researcher’s review of the literature. All manuscripts accepted by this journal (LJC) have included literature reviews that at least accomplished the integration within the field of counseling

###### Scholarship of Application

The third area of scholarship to be considered is the application. The simple question the researcher can ask to test this is: “Am I using or would I consider using this research to benefit the population that I work with?” One of the criterion we use to review manuscripts for the journal (LJC) is the applicability of the research submitted. “Is it of interest to our readers?” and “Can they apply it to their specific setting?” are critical questions in the decision of manuscript acceptance in the journal.

###### Scholarship of Teaching

The scholarship of teaching is focused “in the promotion of safe, motivating, and healthy environments in which potential scholars can learn and advance in the field.” (Duba, 2001, p.3). In the review process, every attempt is made to provide those who submit manuscripts with positive feedback when changes need to be made. It is to this end that we have tried to address the focus of this article to promote and encourage potential scholars. We have also recently instituted a special graduate student section. Articles in this section will primarily be the work of counseling

graduate students. We encourage all students who have not previously been thinking about submitting research to contact a professor at their school and consider submitting some of their research manuscripts. We also hope that those in agency, private practice and school settings would consider manuscript submissions as well. It is our view that the value of research is inherent in improving and advocating for our clients and the counseling profession as a whole.

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-Peter Emerson and Meredith Nelson

Editors

# Section I: Professionals’ Articles

## College Students’ Perceptions of the Mental Health Needs for Fellow Students Returning from Iraq and Afghanistan: Implications for College Counselors

Theodore S. Smith, Danielle M. McClendon, and Kristy D. Fusilier

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After participating in a series of lectures on military service and mental health, 115 college students wrote an essay addressing their perception of the mental health needs for fellow students following deployment. A content analysis of the students’ essays was completed, as the foundation for the present study. Information was obtained from the content analysis regarding the number of cohorts returning, psychological overlay, factors contributing to continued counseling after a first visit, and best provider of counseling services. Results are applied to the provision of counseling services in college settings.

The recent military operations in Iraq and Afghanistan are the first ground combat operations undertaken by the United States since Vietnam.

Research after the first Gulf War showed that multiple veterans returned with psychological overlay, including depression (e.g., Black et al., 2004), suicidal tendencies (e.g., Southwick et al., 1995), and post-traumatic stress disorder (PTSD) (e.g., Orcutt, Erickson, & Wolfe, 2004). Surveys from recently deployed veterans have demonstrated that prior to deployment 5% of soldiers meet the criteria for depression and 9% for PTSD (Kolkow, Spira, Morse, & Grierger, 2007). Although there is an ongoing body of research related to the mental health needs of soldiers returning from Iraq and Afghanistan (e.g., Fontana & Rosencheck; Helmer et al., 2007; West & Weeks, 2006), many

continued gaps exist regarding the mental health needs of returning veterans—particularly related to soldiers returning to college following deployment.

Most recently, the use of peer opinions to direct programmatic planning has gained both interest and acceptance in the medical community. Peer opinion has been utilized to evaluate aptitude assessment of nursing cohorts (Haspeslaugh, Delesie, & Igodt, 2008) and determine clinical effectiveness of healthcare administrators (Kruzich, 2005; Rofoth & Foriska, 2006). Peer opinions have also been utilized to direct nutritional planning (Al-Sendi, Shetty, & Musaiger, 2004) and determine factors contributing to helmet use in teenagers (Lajunen, 2001). It is proposed that peer-based opinions offer a sound

methodology to evaluate programmatic mental health needs for returning veterans.

As an exploratory study, our purpose was to examine the opinions of college students. Recruitment of college students rather than degreed, practicing mental health care providers, enabled the engagement of persons that are not only close in age to those deployed and returning veterans, but also classmates. It is further projected that students would be able to render opinions free from complications of typified mental health planning, such as medical reimbursements (Nissim- Sabat, Farr, McCune, & Stith, 1986) and recruitment and maintenance of personnel (Torralba-Romero, 1998).

Student essays were analyzed using content analysis. Content analysis is typically utilized in the social sciences for analyzing communication, such as professional articles, books, and laws for specific trends of idea threads (Cavanaugh, 1997). Benefits of conducting content analysis versus survey methodologies include simplistic means to describe data (Cavanaugh, 1997) and identification of critical processes used in developing individual opinions (Lederman, 1991).

As such, our study has several goals. First, we employ a methodology not typically utilized to examine prospective mental health needs—peer- based opinions. Second, from the content analysis we examine the number of cohorts returning, psychological overlay among those returning, factors contributing to their continued participation in counseling after a first visit, best provider of counseling services, and perceived person or organization responsible for payment of mental health services.

Third, results are then applied to provision of counseling services in college environments.

###### Method

**Data Collection Procedures**

Across spring and fall 2008 the first author conducted a series of lectures on the mental health needs for returning veterans in a junior-level college class, consisting of both psychology majors (26%) and nonmajors (74%). In each class, students participated in class lectures, read several required articles, and completed an essay—the source of data in the present study. On average, students submitted four to six pages in response to the following essay questions:

1. Do you have a student classmate or acquaintance that has served overseas? Indicate the nature of the relationship and also indicate if the person returned with any psychological overlay. Describe the psychological overlay using terms discussed in lecture.
2. Who do you think (give a specific professional title) will be best able to provide mental health services for returning veterans? Outline the skills and abilities of this professional that would match the needs of the veteran.
3. When do you think returning veterans will initially seek mental health treatment? Give a time period, such as number of weeks, months, years. This is only an estimate.
4. What percentage of veterans will use government-based services? Describe the factors that will affect utilization of these services.
5. What percentage of veterans will use private-pay services? Describe the factors that will affect utilization of these services.
6. Should mental health services be mandatory for all returning

veterans? Provide substantiation for your answer. (You have freedom regarding the “why” component of your answer.)

1. What factors will affect both initiation and discontinuation of mental health services?

###### Content Analysis Process

Following receipt of the papers, a qualitative analysis of the submitted papers was completed by reading through student’s papers, coding and recording students’ main points for each question, and developing a running list of emergent themes within each question. Lists were then compared and a recording sheet was developed to document ongoing themes. The recording sheet was constantly modified, each time adding new themes or combing to accommodate student responses. Themes were tallied for each question. If a response did not fit into a specific category, raters discussed these responses until a consensus could be met regarding placement of a response in a specific category.

###### Inter-Rater Reliability

One initial concern was inter-rater reliability: Were there differences in interpretation across the three raters? Ten random student papers were coded by all three raters, and it was determined that there were no distinct differences or patterns between the raters during spring 2008. The first author randomly selected an additional 10 student papers during fall 2008 and 100% inter-rater agreement was found. High inter-rater reliability was attributed to development of an explicitly developed recording sheet and also continuous communication between the raters.

###### Results

**Participants**

One hundred fifteen students submitted their assignments for this study (six students chose to not participate). Related to college classification, 15% of the students were freshmen, 23% sophomores, 40% juniors, and 22% seniors. Thirty-five percent of the students were majors in the liberal arts, 15% in education, 20% in business, and the remaining student majors were spread across other colleges and disciplines. The mean age was 20.1 (SD=.90).

###### Deployment Status

Sixty percent of the students (n=69) had at least one family member, friend, or acquaintance that had been deployed while enrolled in college, or had plans to attend college following deployment. Associations among those deployed were as follows: friends, 48% (n=36); cousins, 25% (n=19); uncles, 8% (n=6); fiancés, 4% (n=3); other, 3% (n=2); parents, 1% (n=1); and self, 1% (n=1). (Numbers do not equal to 100% as students offered more than one response.)

###### Mental Health Status of Returning Veterans

Fifty-nine percent (n=41) stated that the returning veterans exhibited mental health problems such as depression, PTSD, and anxiety disorder, while 32% (n=22) did not, and 9% (n=6) were still deployed. Mental health symptoms exhibited by the veterans were as follows: personality changes, 23% (n=16); relationship problems, 13% (n=9); substance abuse, 13% (n=9); personally distant or isolated, 13% (n=9); nightmares, 11% (n=8); trouble sleeping, 10% (n=7); aggression, 6% (n=4); depressed, 3% (n=2); panic attacks, 3% (n=2); and PTSD, 1% (n=1). (Numbers do not equal to 100% as students offered more than one response.) If responses indicated that a

psychological disorder was pre-existing prior to deployment, then the disorder was not counted as a post-deployment residual.

Breakdown of the student perceptions related to the percentage of students needing mental health services following deployment were as follows: less than 10%, 0% (n=0); 11-

20%, 3% (n=3); 21-50%, 26%, (n=29);

51-75%, 7% (n=8); and 76-100%, 63%

(n=70). Two percent commented (n=2) that the mental health care needs would vary across veterans.

###### Utilization of Government-Based Mental Health Services

Student perceptions related to the percentage of students that would utilize government-based mental health services following deployment were as follows: less than 10%, 9% (n=20); 11-

20%, 18% (n=20); 21-50%, 51% (n=56);

51-75%, 12% (n=13); and 76-100%, 6%

(n=7). Reasons given by students for veterans not using government-based services were as follows: stigma, 40% (n=46); availability of services, 23% (n=27); financial, 22% (n=25); readiness, 19% (n=18); will not need if have family support, 10% (n=11), will not need if no problems, 8% (n=9); gender, 7% (n=8); transportation, 5% (n=6); culture, 4% (n=5); and varies individual basis, 3% (n=3). (Numbers do not equal to 100% as students gave several students gave more than one comment.)

###### Utilization of Private-Pay Services

Breakdown of the student perceptions related to the percentage of students that would utilize private-pay mental health services following deployment were as follows: less than 10%, 38% (n=36); 11-20%, 15% (n=14);

21-50%, 39% (n=37); 51-75%, 5%

(n=5); and 76-100%, 2% n=2).

Reasons given by students for veterans not using private pay services were as

follows: financial, 67% (n=77); availability of services, 18% (n=21); readiness, 10%, (n=12); stigma, 27% (n=31); time, 2% (n=2); age, 2% (n=2); sex, 3% (n=3); waste of time, 5% (n=6); culture, 4% (n=5); treat pre-existing condition, 2% (n=2); and jeopardize employment, 2% (n=2). (Numbers do not equal to 100% as several students gave more than one reason.)

###### Mental Health Care Provider Selections

A variety of responses were offered regarding the best perceived mental health professionals for providing counseling services. It is important to note that prior to this assignment two lectures were offered regarding duties, education, licensure requirements, and roles of individual mental health care providers in the community, offering all students the same theoretical and practical framework for these professionals. Most students (44%, n=51) indicated that a psychiatrist would be best suited to provide mental health services for returning veterans. Additional recommended service providers were as follows: psychologist, 33% (n=38); Licensed Practical Counselor, 22% (n=25); paraprofessional, 13% (n=15); Licensed Rehabilitation Counselor, 10% (n=12); and Social Worker, 1% (n=1).

Supplementary comments made by students included the following: combination of professionals, 15% (n=17); individual choice, 3% (n=3); not paraprofessional, 2% (n=2); any acceptable, 2% (n=2); and any available, 2% (n=2). (Numbers do not summate to 100% as several students gave more than one professional and/or additional comments.)

###### Initiation of Mental Health Services

A distribution of time frames when a veteran would initially seek treatment as per student opinions is

delineated as follows: less than 1 month, 10% (n=10); 1-6 months, 38%

(n=46); 6 months – 1 year, 25% (n=30); and greater than 1 year, 16% (n=19).

Students also indicated that initiation would vary on an individual basis (10%, n=12), and family intervention would prevent need for services (2%, n=2).

###### Discontinuation of Mental Health Services

Students’ perceptions of factors affecting a veteran’s choice to continue or discontinue mental health care after the first visit are indicated below: counselor characteristics, 23% (n=55); financial, 16% (n=38); evaluation only needed, 11% (n=47); personality, 8% (n=18); availability of family support, 8% (n=16); individual readiness, 4% (n=9); other priorities, 4% (n=9); severity, 3% (n=7); stigma, 3% (n=6); and availability of services for additional appointments, 3% (n=6).

Other responses (<2%) included transportation, wait times, sex, education, age, and additional deployment.

###### Mandatory Mental Health Services

Seventy-four percent (n=85) indicated that that all veterans will need mental health care, whereas 26% (n=30) indicated that veterans would not require mental health care upon returning. Justifications for mandatory mental health services are outlined below: need initial evaluation, 51% (n=59); enable nontraditional veterans’ access to care, 13% (n=15); not effective if against veteran’s will, 10% (n=12); component of government responsibility, 6% (n=7); must be individual choice, 6% (n=7); government overstep role, 6% (n=7); public safety issue, 9% (n=10); minimum 3 sessions all veterans, <1% (n=1); and need to educate veteran about mental health services, <1% (n=1). Students also indicated lack of

available services may prevent realization of mandatory mental health services (<1%, n=1), and mandatory services must be provided because mental health care is inevitable (<1%, n=1).

###### Discussion and Implications for College Counselors

**Deployment and Mental Health Status Returning Veterans**

College students in the present study were of the opinion that fellow college veterans will probably display psychological overlay upon their return. These opinions are in concert with studies from prior wars, including Vietnam (e.g., Brooks, Laditka, & Laditka, 2008; Koenen, Stellman, Sommer, & Stellman, 2008) and the first Gulf War (Black et al., 2004; Reeves, Parker, & Konkle-Parker, 2005). Mental health predicaments, as predicted by student opinions, ranged from problems in relationships and work, depression, and development of addictions. Results in the present study further concur with prior studies that have shown strong relationships between stress and psychological overlay in veterans, including aggression (Forbes et al., 2008) and depression (Cully et al., 2008).

###### Utilization of Government-Based and Private-Pay Mental Health Services

In the present study students indicated that the main barrier to veterans using both types of services was social stigma. Students particularly indicated, “the soldier would appear weak seeing a counselor,” “soldiers are too tough to discuss their problems,” and, “they will have to accept weakness if they use counseling services—they will not be able to accept that they need help.” Particularly linked to veterans returning to college campuses, one student remarked,

“perhaps the counseling center should not be so prominently placed close to the Student Union…everyone will know if someone is messed up.” College counselors may consider evaluating perceptions of stigma through the use of psychometric instruments recently normed with college students (Vogel, Wade, & Asheman, 2009). Several programmatic suggestions have been recommended to reduce stigma, including social constructivism (Kondrat & Teater, 2009), and focusing on the role of religiosity as a component of the counseling process (Lee, Puig, & Clark, 2007). Financial barriers represented another major barrier to counseling services. Considering the financial stressors typical of returning veterans (e.g., Bookwala, Frieze, & Grote, 1994; Cohan, Cole, & Davila, 2005), resources may not available if they were not offered free or at low-cost. Individual differences (e.g., sex, age, culture) were further identified as factors affecting utilization of services. It would be recommended that utilization of public education initiatives and development of peer counseling networks may address this later issue.

###### Selection of Mental Health Care Providers

There was a disconnection between the availability of persons to provide services on college campuses and student opinion as to the appropriateness of those persons serving. Although the role of psychiatrists on the college campus has been minimally addressed in the literature (see Cadoret & Rohen, 1973 for an exception), the college environment dictates that psychiatrists are not typically available in the college counseling center. Alternatively, students indicated a reduced level of acceptance of Licensed Professional Counselors, paraprofessionals, and

Rehabilitation Counselors. Interestingly, a small percentage indicated not one, but a variety of professionals may appropriately provide services. A review of the essays suggested that students realize prescriptive care must be coordinated with mental health care. For example, a student succinctly indicated, “…a single professional is not feasible, as a physician (psychiatrist) must coordinate medication, while a paraprofessional can provide day-to- day care.” Indeed, another student commented, “…it doesn’t matter about a title, as long as the professional is qualified, or knows someone that is qualified to provide quality services whenever a question can’t be answered.” Although verbose, this comment suggests a reality—services must be coordinated.

###### Initiation and Discontinuation of Mental Health Services

Veterans may vary regarding the time period in which mental health services are accessed, ranging from less than three months to greater than three years. The time period of first mental health overlay may vary following combat. Considering the extended time period when veterans access services, numbers suggest that many soldiers will not access services immediately upon return to college, and college students returning from service may bypass collegiate-based counseling services entirely. One student commented, “…I think soldiers will not seeking [sic] counseling for awhile after returning…they will spending 2-3 months greeting friends, relatives, and just catching up… life will start to get quiet 8-12 months after deployment and at about 12 months he/she will seek counseling, but then again, one may not be ready for counseling until

2-3 years following initial deployment.” Also, research is beginning to show that

solders tend to display “post-combat invincibility,” perhaps prompting suspension of counseling services (Kilgore et al., 2008). College counselors may consider completing an initial evaluation, as recommended earlier, and providing follow-up to assess any changes during the veteran’s continued tenure.

Several reasons were offered as potential reasons students may not return after the initial counseling visit with characteristics of the counselor identified as the main contributing factor. Several students commented that “personalities need to match,” “the counselor will make or break continuation of counseling services,” and “if the counselor and soldier do not get along, the soldier will not seek additional counseling after the first visit.” As such, utilization of peer counselors, or peer group therapy formats may prompt continuation of therapy by the veteran.

The negative and positive effect of mandatory psychotherapy for college students has been previously addressed in the literature with a lack of consensus, particularly linked to legal, ethical, clinical, and disciplinary issues (Gilbert & Sheiman, 1995). However, a review of comments suggests that a differentiation must be made between mandatory counseling and mental health screening. Essays indicated that students’ opinions tend to focus toward the latter. For example, several students indicated, “…mandatory services should be required, especially to complete an evaluation upon their return,” “mandatory services may not be beneficial if a soldier is not ready for counseling…a psychological evaluation every so often may screen for when services are needed,” and “…not all soldiers will need counseling, but all soldiers will need to be evaluated in case the soldier has some mental health problems.”

###### Academic Planning Acute and Chronic Conditions

Of particular interest to the college counselor is academic planning with acute versus chronic conditions.

Military returnees face several psychological challenges within and outside of the academic setting. After many months of deployment in a combat-ready, constantly-arousing state, it can be difficult to settle-down into quiet academic domesticity. Many students may not be able to leave their combat-ready mindset behind, as they appraise their academic goals through studying, classroom participating, advising, and other academic activities. Family and domestic environments may have changed following return home.

Adjustment in a university setting may be difficult for students, as the cohesiveness between student-student and student-professor may be far different from the climate of a military unity. Furthermore, the college student may find it difficult to feel challenged, stimulated, or interested in taking psychology (or any courses) because they were aware that on a few months previously they were making “life and death” decisions. Returning veterans may also have difficulty concentrating on academics because of preoccupation with past military scenarios, disruptive home life, and other distracters.

Different individuals will return to academic settings with variable levels of readiness and success. Some will successfully return within weeks, others may need more time and assistance, and others may never succeed. As such, readjustment is a complicated process with no clear demarcation and framework for determinable success. Professors, college counselors, and support staff confronted by veterans need to be aware of the complicated nature of readjustment. Importantly, academic

difficulties may be representative of other clinically significant problems, requiring counseling centers to focus on holistic programmatic components.

###### Services Available through Veterans’ Administration

It is important for college counselors to understand that some Veteran’s Administration centers do complete initial screenings for psychological overlay. As such, if a college student seeks counseling services from a university-based center after visiting a VA center for the same service, the college counselor may wish to contact the local VA center to obtain records to document continued progression of mental health status. Currently, soldiers returning from a deployment have a variety of available services.

Following an initial phone assessment, soldiers are paired with a treatment provider, and the soldier is allocated 12 sessions per issue, with requests for additional services being addressed on an as needed basis. Services can range anywhere from free to a reduced cost depending upon the facility. In some cases, such services are also offered to the spouses and family members of the soldier regardless of their own university enrollment status.

###### Mental Health Needs of Family Members

The present results suggest that family members and friends will be affected following deployment. This would be in agreement with previous studies that have demonstrated presence of psychological overlay among cohabitants and family members of relatives from the Vietnam era (Sherman et al., 2005). The impact of mental health issues experienced by veterans has also been shown to affect spouses (Eaton, 2008), particularly impacting relationship satisfaction (Hamilton, Nelson Goff, Crow, &

Reisbig, 2009). Eaton (2008) additionally proposed that spouses display depression and generalized anxiety disorder at similar rates as their returning spouses. As such, this suggests family members and friends may also benefit from counseling services.

###### Conclusion

At the time of this writing, the termination date for these wars is undetermined and soldiers are serving multiple tours. Anecdotally, the first and third authors are beginning to counsel students that have served two and three tours in the Gulf. The range of adjustment success following deployment has varied, with some students successfully pursuing and completing college curriculums, and others requiring specialized adjustment counseling and academic tutoring. As PTSD often takes years to manifest itself, the impact of military service on college counseling services is still unknown. In the present study, it was proposed that college-students offer one mechanism for evaluating the needs of these veterans, particularly veterans returning to college following deployment. It is recommended that opinions from multiple peer sources, such as spouses, employers, fellow employees, and others offer further insight into the mental health needs of these veterans in addition to more traditional needs-based assessments.

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## Batterer Intervention Programs: The Relationship between Session Completions and the Batterer’s Perception

of the Abusive Relationship

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The purpose of this study is to investigate the male batterer’s perception of his relationship with his partner and the impact the relationship has on session attendance and program completion in a batterer intervention program. The study investigated 198 male participants enrolled in a batterer intervention program in the southeastern United States. The findings suggest a complex interaction among the three variables of (1) the participant’s perception of the referral incident, (2) the batterer’s emotional commitment to the victim, and (3) the total number of sessions completed in a batterer intervention program. The implications of demographic and psychological variables affecting session attendance are discussed.

Life, James and Gilliland (2005) define battering, or intimate partner violence (IPV), as any form of physical violence perpetrated by one partner against the other in a romantic relationship. The abuse may be physical, emotional, sexual, or a combination, with the abuser using violence, threats of violence, and verbal degradation (McLeod, Muldoon & Hays, 2010). Arias, Dankwort, Douglas, Dutton, and Stein (2002) estimate that annually, 1.5 million women become victims of battering by an intimate partner, although most incidents are never reported to the police (McLeod et al., 2010; Tjaden & Thoennes, 2000).

Battering occurs in all socioeconomic, racial, ethnic, and religious groups and is afflicted by men and women in heterosexual, gay, and lesbian relationships. This study focuses on male batterers in heterosexual relationships.

Batterer intervention programs are a common and well-established

therapeutic (but not necessarily empirically validated) intervention for men who batter women (Arias et al., 2002; James & Gilliland, 2005; Levesque, Driskell, Prochaska, & Prochaska, 2008a; Levesque, Velicer, Castle, & Greene, 2008b). The typical batterer intervention program lasts 26 to 52 weeks in duration, depending upon state requirements, and can consist of either open or closed group work. Batterer intervention programs have several goals. They strive to help batterers to (1) acknowledge their violent behavior and accept accountability for their behavior; (2) help them express healthy emotions and use alternative and positive coping skills; (3) strengthen their communication and anger management skills; (4) curtail their control and power in intimate relationships; (5) assist them to identify the dynamics of abuse and its effects on others; and (6) recognize their triggers or cues that initiate their violent behavior (Domestic

Abuse Project, 1993; McLeod et al., 2010).

In spite of the documented success of batterer intervention programs, batterers’ resistance to therapeutic intervention is well documented (Levesque et al., 2008b). Their resistance to treatment intervention results in treatment refusal, premature termination (i.e., drop out), and violence recidivism (Kistenmacher & Weiss, 2008). Numerous authors have examined various predictors of program attendance and completion for batterers referred to intervention programs (McLeod et al., 2010; Rosenberg, 2003; Snyder & Anderson, 2009). Batterers’ personal factors such as age, educational level, employment status and previous exposure to violence as a child, offer fairly solid predictive value as to whether a batterer will attend an intervention program (Cadsky, Hanson, Crawford, & Lalonde, 1996; Daly, 1997; DeMaris,

1989; Gondolf & Foster, 1991; Grusznski & Carrillo, 1988; Hamberger, Lohr, & Gottlieb, 2000; Saunders & Parker, 1989).

Batterers’ psychological factors are another area that has been connected to predictors of program attendance and includes their involvement in a committed relationship. Gondolf (1988) asserted that the impact of the “woman factor” in a committed relationship provides social and emotional support for the batterer and fear of loss of the “woman factor” may motivate some batterers to complete treatment. The impact of the significant other on the batterer should not be minimized and is an important aspect of this research.

If the batterer perceives a high level of intimacy and commitment to his partner, his motivation to change is usually heightened (Daly & Pelowski, 2000). That is, if he perceives the relationship as physically and emotionally intimate, he will more likely

be motivated to comply with treatment directives than if he perceives the relationship as a casual one, in which case he would be less likely to be motivated to change. Research suggests that batterers’ who are married or cohabitating are more likely to complete treatment requirements than are single batterers or those in uncommitted relationships (Daly & Pelowski, 2000; Cadsky et al., 1996).

Those batterers in committed relationships tend to receive social and emotional support, encouragement, and stability from their partner. This “woman factor” (Gondolf, 1988), the occurrence in which persuasion and support from a spouse or partner, motivates an individual to participate in and comply with treatment. Conversely, DeMaris (1989) found that men who were not married or cohabitating, were unlikely to complete treatment.

Regardless of the presence of personal, psychological and relationship factors, the typical male batterer is primarily motivated externally to change. One typical external motivator is court mandated treatment (Stordeur & Stille, 1989; Kistenmacher & Weiss, 2008; Buttell & Carney, 2008; Levesque, et al., 2008b). That is, batterers attend intervention programs when criminal justice personnel require participation in treatment programs and threaten incarceration and/or fines for non- compliance (Gondolf, 1997). Yet, a court mandate to participate in an intervention program does not ensure treatment completion (Iruestes-Montes & Montes, 1988). However, the interactions among (1) external motivating factors (DeHart, Kennerly, Burke, & Follingstad, 1999); (2) psychological factors (Hamberger, Lohr, & Gottlieb, 2000); and (3) personal factors (Daly & Pelowski, 2000) have been associated with improved attendance at and participation in

batterer intervention programs. These variables constitute an index of "marginality," or the assessment of what assets (e.g., employment, relationship, & children) are at stake for a man to lose (or maintain) (Sherman, Schmidt, Rogan, Smith, Gartin, Cohn, E. G., & Bacich, 1992; Cadsky et al., 1996). For instance, a man who is not married and is unemployed has few assets to lose, is “marginal” and is less likely to be motivated to complete court mandated treatment when compared to a man who is married or cohabitating and employed. Hence the married and/or employed individual realizes that treatment non-compliance is a high- stakes gamble which may result in incarceration and/or the loss of his assets. Therefore he is motivated to change and to minimize further social and financial losses incurred through court action.

Finally, Hamby and Gray-Little (2000) determined that, among women, it was only the more frequent and more severe violent incidents that were labeled as partner violence. It can be hypothesized that males ‘label’ domestic violence in a similar manner as females; therefore an incident with ‘only’ a slap is seen as being inconsequential…until one is arrested and incarcerated. This experience of being arrested and incarcerated might allow men to perceive either their relationship status or referral incident (the incident that is a catalyst for their referral to treatment) or both in an entirely different and healthier manner. Such ‘insight’ has often been spoken by men in batterer intervention programs who stated that they never want to experience incarceration again.

Therefore, something has to change.

So, the rationale for this study rests on the lack of research that exists connecting these three distinct variables. The hypothesis is that

participants who perceive their relationship as being intimate (individuals are committed to the relationship) and see the referral incident as being different (more severe than previous incidents), will attend more intervention sessions.

To determine the accuracy of this hypothesis, data was gathered through a structured intake interview to answer the research question about what extent will a batterer who perceives he is committed to his partner be more or less motivated to attend an intervention program. This study will explore the nature of the relationship between (1) the batterer’s perception of the incident that resulted in his referral to an intervention program and (2) the perceived commitment of the relationship by the batterer that will be measured by the total number of intervention sessions completed.

###### Method

**Participants**

This study involved one group of men that participated in a batterer intervention program in a primarily rural area of the southern United States. The participants were referred either voluntarily, meaning they enrolled of their own volition, or through a court mandate by county magistrates, municipal judges or state probation officers. All male individuals enrolling in the program in 2002 were told about the research study. Those that agreed to participate in the research signed a consent form noting their agreement. The participation response rate was extremely high. It is conjectured that individuals agreed to participate because they thought that both the research and program participation were required as a condition of their court mandate, despite being told they had to complete the program but not the research.

The subsequent sample consisted of 198 men. With regard to ethnicity, 56.6% (n=112) were African American and 43.4% (n=86) were Caucasian. In terms of marital status, the participants classified themselves as 36.9% (n=73) married, 25.3% (n=50)

single, 17.2% (n=34) cohabiting, 12.1% (n=24) separated, and 8.6% (n=17) divorced. The age range of participants was from 17 to 70 and the average age was 33.61 (SD=9.89). Data regarding referral status (voluntary, mandated) was not available, though it is probable that a large majority were court referred.

###### Design and Procedure

Data were collected in 2002, on male individuals enrolled in a domestic violence offender program. The program operated throughout the northeastern region of a state located in the southeastern United States.

Information was gathered through a structured intake interview lasting approximately one hour and completed by trained professionals. It was necessary during interviews to seek probing and challenging questions to verify the accuracy of the information given. For example, if an individual hit the victim, inquiries were made about whether it was with an open hand or closed fist. Individuals were also asked about the degree of force that was used and was compared to the extent of bruising on the victim. Otherwise, all elicited information was self-reported in nature and, after clarification, was accepted as an accurate reflection of the batterer’s perception.

Each member was required to attend a psycho-educational group session once per week for 2 hours for sixteen weeks. A continuous measure of the total number of weekly group sessions attended by participants was used to define attendance. The number of sessions attended was extracted from

attendance sheets and group notes maintained by staff workers and group facilitators for each participant. The number of sessions attended allowed for the use of parametric statistical analyses in connection with the status of the victim and the nature of the referral incident. All data was collected once. There were no additional requests for data collection or follow-up.

###### Intake Process

Information was gathered on participants’ demographic and contact information. Data was also obtained on life histories including mental health treatment, substance abuse treatment, involvement with the state department of social services, and medical information (use of weapon, injuries).

Particular interest was paid to criminal activity, which was separated into the following categories:

1. Domestic Violence (occurs with a significant other)
	1. Criminal Domestic Violence (CDV) I & II - misdemeanor offenses seen in municipal and magistrate courts
	2. Criminal Domestic Violence (CDV) III - felony offenses seen in general session court
2. Other Violent Charges (occurs with a person who the offender is not intimate)
	1. Assault - physical (punch, kick, slap) incident with minor or no marks or bruises
	2. Assault and Battery - use of a weapon to inflict or threaten bodily harm

Participants were also asked why they were attending the program. All of this information was obtained in a question and answer format using a

combination of open (“What is the most severe argument you’ve had with an intimate partner?”) and closed questions (“Have you ever been arrested?”).

###### Referral Incident

As part of the intake procedure, participants were asked to detail what happened in the event that subsequently led to their referral to the program. Individuals were also asked to respond to several questions about violence in their relationship; including what was the worst violence they had engaged in, if the current incident was the first physical one, if weapons were used, or if medical treatment was needed. Additionally it was asked, “Has there been an increase or decrease in the use of violence in the relationship by the participant?” Participants were also asked to identify whether or not the incident that led to his referral to the batterer intervention program was different in any way from previous incidents and why.

Individuals were then asked to respond to an open ended question. The question was purposefully worded in order to see if the participant’s perception of the referral incident was viewed as being different in any way relative to other incidents. Many participants had previous incidents that involved verbal and emotional types of violence (use of profanity, accusations of infidelity), but this incident was the first one that included physical violence or the level of physical violence was more severe this time. For those participants that responded no, that the incident was not different, there was generally no further question for clarification. In some sense, the questions about the history of domestic violence were to evaluate whether the violence was becoming more severe.

###### Victim’s Status

As part of the standard intake procedure, participants were asked to identify by self-report their relationship status with the other person involved in the referral incident. For this research, an intimately related individual was defined as being someone with whom the participant has had romantic relations such as a spouse, girlfriend, or ex-girlfriend. A non-intimately related individual was classified as being someone with whom the participant did not have a romantic relationship and included children, parents, and current partners of a former partner (a former girlfriend’s boyfriend). After giving his response, researchers coded the individual as either intimately related or non- intimately related based on whether there was a romantic aspect of the relationship.

###### Intervention Program

Participants enrolled in the program were required to meet once per week for two hours for 16 sessions in a batterer intervention program. The 16 sessions represented a modified version of the 10 group sessions inherent to the Duluth Model originally proposed as part of the Domestic Abuse Project’s Curriculum (Domestic Abuse Project, 1993). As part of the outlined rules of the program, individuals were required to restart the program after accumulating more than 2 unexcused absences. As such, it was possible for an individual to attend more than the required 16 sessions, if any restarts were necessary. Therefore, so as not to differentiate between those that were dismissed from those that attended consecutively, sessions were counted regardless of whether they had to restart. It is noteworthy to consider that, for court mandated participants, the decision about being able to begin the program again was often not within the control of the program staff. This

research was not intended to determine the degree of engagement in the treatment process, regardless of the number of sessions completed.

###### Results

**Traditional Predictor of Attendance**

Traditional demographic variables associated with batterer program attendance were examined. Results of one-way ANOVAs for age, income, and educational attainment revealed no significant effect on program attendance. After exploring these traditional predictors of program attendance, focus shifted to include variables related to the purpose of the study.

###### Referral Incident

As part of the intake procedure, participants were asked to identify whether or not their referral incident differed in terms of level of aggression from previous domestic disputes. The purpose of this question was to determine if there was an increase in the severity of violence. As such, individuals were forced to respond either yes or no to whether they thought this incident was different from other incidents. Examples of incidents that were reported to be different included that this was the first use of physical violence or that the violence was more severe. In order to examine these responses, an independent samples test was performed. Analysis revealed a significant difference with regard to the participants’ perception of the referral incident as it related to session attendance, where t (170)

=2.54, p=.01. Specifically, when the participant viewed the referral incident as different, he attended significantly more sessions (M=11.73, SD=6.76) as opposed to individuals viewing the referral incident as not different (M=8.69, SD=6.86).

###### Victim’s Status

Also part of the standard intake procedure, participants were asked to identify the other person involved in the referral incident. After participants gave their response, researchers coded the victim’s status as either intimately related or non-intimately related.

Subsequently, an intimately related individual was defined as being someone with whom the participant has had romantic relations (i.e. spouse, girlfriend, ex-girlfriend, etc.). Non- intimately related status was indicated by responses such as friend, associate, or other relative (cousin, in-law, etc.). In order to examine participant responses, an independent samples test was performed. However, no significant differences were discerned between a participant’s session attendance and whether the victim was intimately related or not intimately related.

The significance of these two variables is important when considering the means of the groups. Specifically, when the participant’s victim was intimately related and the participant viewed the referral incident as being different than any prior incidents, he attended an average of 11.73 sessions. Comparatively speaking, he attended an average of 8.69 sessions when the victim was intimately related and he did not view the referral incident as being different than any prior incidents.

However, when the victim was intimately related and the participant viewed the referral incident as different from any other incident, he attended an average of 12.37 (SD=.672) as opposed to an average of 7.86 (SD=1.13) sessions when he did not view the incident as being different from any other incident. Hence, session attendance was significantly better when the participant viewed the referral incident as different and the victim was intimately related. See figure 1 below.

###### Figure 1

Session Completion, Victim Status and Perception of the Referral Incident

Sessions completed:

A function of victim and perspective

13

12

11

10

9 Different Incide nt

8 No

7

Intimate Partner

Yes Non-Intimate Partner

###### Discussion

Victim 's s tatus

violence is a stronger possibility. Then program staff can interact with domestic violence advocates and other

The results of this study highlight several important issues in eradicating domestic violence. First, there was an interaction effect among victim relatedness, the number of sessions attended, and the batterer’s perception of the referral incident as different in terms of violence. This finding indicates that the more emotionally involved or committed a man that batters is to his partner, the more likely he will attend more intervention sessions.

A second significant finding is the complex interaction of these variables relative to treatment completion and successes. Therefore, if an individual stated that he is not committed to the victim, the likelihood of additional

members of a response network to alert them to the possibility of future violent acts, both in terms of severity and frequency. Additionally it can be hypothesized that those batterers that perceive the victim to be intimately related will attend more intervention sessions.

The findings of this study suggest the need for a pre-program assessment of how the batterer perceives the status of his relationship with his partner (intimate or not) and the status of the referral incident (different or not) with respect to the number of sessions attended. It should be noted that many men stated that they were living with their partner yet did not report her as a

girlfriend or other significant partner. An individual’s perceptions regarding the referral incident and the status of the victim may serve as the motivation for attendance in batterer intervention programs as well as his motivation for change. As noted in the introduction, there also does not appear to be any studies linking these three variables. From a practical perspective, it is doubtful that batterer programs are inquiring about relationship status or understand the continuum of relationship violence.

Certainly these findings have implications that directly impact the intake and assessment protocols for the evaluation of batterers and its impact on the treatment process. Findings should also impact how batterer intervention programs train individuals who conduct intake assessments and who lead batterer intervention programs. One suggestion is to inquire about all instances of domestic violence and the severity of each incident, including use of a weapon, medical treatment needed and the extent of bruises. The idea is to determine how the referral incident relates to other incidents. For example, a referral incident is different because this was the first one that involved physical violence. In addition, inquiries can be made about where violent incidents occur. It can be deduced that, if an individual is willing to perpetrate domestic violence in a public setting (supermarket, parking lot, etc.), that individual is at a higher risk of additional violent incidents and more likely to induce physical harm to a partner.

The data suggests that men who value their relationships and have experienced a perceptively ‘different’ episode of abuse bring to the batterer intervention experience a type of internalized motivator, namely the relationship. Intuitively, perhaps as a

result of this internalized motivator, these men attend significantly more group sessions. In contrast, those individuals who perceive their incident of abuse (reason for referral to treatment) as not being different might respond to a different motivating factor, such as stricter consequences for nonattendance. The differences in perception of the referral incident suggest different methods of ending the cycle of violence and abuse. In short, it is conjectured that there are many plausible reasons why men attend intervention sessions. This research is important in that it suggests that commitment to a relationship is another reason why men attend intervention sessions.

###### Limitations and Future Research

There are limitations to this study. This is one group of 198 men. This is also one program in a specific geographic region of the country. The results of this study are not generalizable. The exception, relative to generalization, is that there are other areas of the country that have a similar rural to small town composition. Even then, the demographic comparison is not likely to be similar. Additionally, there are other confounding factors that could have affected the results reported. Some of these factors include additional pressure or consequences from the court mandated referral source to attend/complete the program or other learning that occurred outside of the intervention sessions that motivated individuals to continue attending sessions.

Another limitation of this study is the validity of the self-reported information by the research participants. It is fairly well known that batterers tend to minimize the severity of the abuse they perpetrate. In addition, the majority of the participants were referred by the

criminal justice system. Therefore, participants had no reason to self report the accuracy of the violence that occurred in their referral incident, especially if they thought it would incur more consequences.

However, there are two important aspects to consider. One is that court officials have little time or resources to enforce additional consequences should a participant offer more detailed abuse in the program’s intake interview than was originally introduced in court at sentencing. Second, the importance of establishing a therapeutic relationship with each participant is part of obtaining accurate information. In concert with therapeutic alliances, we allowed participants to understand that there is a difference between an agent of the court who can extol consequences and a counselor who can facilitate positive behavior change through imparting information, following program rules and challenging inappropriate behaviors. Relative to the therapeutic alliance, there is a degree of confidence given, except when program staff believed a victim or her family or friends were threatened. Therefore, when an individual reported information, we believed he was telling the truth.

Given the findings of this study, more research needs to be conducted to include additional variables. Other factors that need to be considered include number of sessions attended, the length of time the violence went unreported, and the number of times the abuser needs to be readmitted.

Several characteristics about the referral incident on a continuum of violence and its affect on the victim need to be researched. Items include whether or not weapons were used and how were they used (pointed/shot a gun, safety lock on/off, loaded/not loaded) and whether the victim felt threatened and to what degree.

Ultimately, research needs to assist in determining how to engage batterers in the treatment process. It may be that the number of sessions completed is inconsequential when considering employment, education, or, as in this study, relationship status and increase in violent behavior.

###### Conclusion

This study investigated the male batterer’s perception of his relationship with his partner and the impact of that relationship on session attendance and program completion in a batterer intervention program. The sample for the study was 198 male participants enrolled in a batterer intervention program in the southeastern United States. The findings suggest a complex interaction among the three variables of

(1) the participant’s perception of the referral incident, (2) the batterer’s emotional commitment to the victim, and (3) the total number of sessions completed in a batterer intervention program. Two conclusions are of importance. The first is that participants who identified their relationship as being intimate, or as a romantic relationship, attended more intervention sessions than those who perceived a non-romantic relationship. Second, participants who perceived the referral incident as different (worse, physical, etc.) attended more intervention session than those who did not. The implications of demographic and psychological variables affecting session attendance were then discussed. Limitations of the study and directions for future research were also noted. In summary, this research suggests that participants in batterer intervention programs explore the importance of the romantic relationship, a variable that has not been previously considered, as a way to

motivate them to decrease or eliminate their violence against intimate partners.

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## Grandparents Raising Grandchildren: The Effects, Counseling Challenges, and Strategies

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For more than 20 years the number of grandparents who have taken over the role of the primary custodial caregiver of their grandchildren has steadily increased. There has been burgeoning investigation and interest into this phenomenon that affects the largest segment of the U.S. population, the baby boom generation, as well as older adults. This report provides an overview of the most critical issues that have been covered in the literature and identifies some of the challenges for counselors who work with both the grandparents and the children. Some counseling strategies that have been shown to be promising in dealing with complex trauma are discussed as well as questions for future research.

The role of grandparents has been shifting in the past 20 years in that more middle aged and older adults in the U.S. are raising their grandchildren (Edwards, 2009; Hayslip & Kaminski, 2005; Kreider, 2008; Lugaila & Overturf, 2004). This is linked to a complex array of generational and developmental transitions of the past three generations and most significantly with the Baby Boom generation. Even though the arrangement of grandparents assuming care for their grandchildren has existed for decades, the increasing number of children who spend a significant portion of their childhood in the full- time care of their grandparents is a rather recent development (Hayslip & Kaminski, 2005; Strom & Strom, 2000). In African countries and during the late 1980s and early 1990s in the U. S. the HIV/AIDS epidemic contributed to grandparents assuming the parenting

role (Joslin, 2000b), but the reasons for custodial grandparenting in the U.S. and Canada are as varied as the myriad of dynamics that affect family life (Fuller-Thomson, 2005). The current reasons that grandparents provide custodial care for their grandchildren include what some researchers have called the “four Ds”: death, desertion, divorce, and drugs (de Toledo & Brown, 1995; Glass & Huneycutt, 2002) as cited in Edwards, 2009, as well as three other “Ds”: disease (HIV/AIDS), duties (military deployment), and detention in prison (Edwards, 2009, p. 130).

Very often grandparents are raising the most vulnerable children. Thus, the impetus for this report is to address some of the significant effects of this shift in family life and the issues that counselors and family therapists encounter in working with grandparents who are providing kinship care for their grandchildren. The

counseling strategies discussed are those that are pertinent to the grandparents’ presenting problems, particularly understanding and managing disruptive behaviors at home and at school. These disruptive behaviors are frequently the result of the children’s experience of complex trauma, e.g. being removed from parents, rather than intentional choices. Well-informed counselors may at times use this perspective of the grandchildren’s disruptive behaviors as a way to help the grandparents understand and influence some shift in the children’s behaviors.

###### Overview of Custodial Grandparents in the U.S.

For more than 20 years the number of grandparents who have taken over the role of primary caregivers of their grandchildren has steadily increased (Lugaila & Overturf, 2004). The U.S.

2000 Census showed that approximately 4.5 million children were living in a household headed by a grandparent. One in ten grandparents provides custodial care for grandchildren for six months or longer (Fuller-Thomson & Minkler, 2005).

More recently, the U.S. Census 2004 Report on the living arrangements of children shows that nearly 1.6 million children live with their grandparent(s) with no parent present (Kreider, 2008). These snapshots of the efforts of many grandparents are particularly poignant considering the dramatic shifts in family life, the labor market, the economy, the political climate, health care, and the diversification of society as a whole in the U.S. The current 2010 Census may show that this trend is continuing in the 21st century as it had in the last decade of the 20th century.

Grandparents take over the parenting role due to a variety of issues affecting their adult or adolescent

children: substance abuse, HIV/AIDS, mental illness (primarily bi-polar affective disorder, schizophrenia, and depression), parental incarceration (often due to drug offenses by the mother), child abuse and neglect, dysfunctional family situations, gang involvement of the parents, military deployment of the parents, and parental death (Edwards, 2003; Joslin, 2000a; McGowen, Ladd, & Strom, 2006). Moral and religious principles and not wanting the children to be in foster care also play significant roles in the grandparents’ decision to provide support (Burton, 1992; Edwards, 1998). In fact, about three-fourths of the grandparents take over the parenting role when their grandchildren are infants or preschoolers (Fuller- Thomson & Minkler, 2000a; Fuller- Thomson, Minkler, & Driver, 1997) with boys being in the majority of the children raised by their grandparents (Hayslip, Shore, & Lambert, 1998).

Children being raised by their grandparents are from diverse groups. Even though this phenomenon crosses class, gender, and ethnic groups, many of the grandparents are African American single women, who have incomes at or below the poverty line (Edwards, 2000; Fuller-Thomson & Minkler, 2000a; Kreider, 2008). Slightly more than 50% of these “grandfamilies” (Edwards, 2003) involve married grandparents, although many more of the custodial grandparents are unmarried when compared to non- custodial grandparents (Minkler & Fuller-Thomson, 1999). For some married custodial grandparents, the challenges of caring for grandchildren who have behavioral and emotional difficulties may contribute to marital distress. Marital problems, in turn, may complicate the adjustment of the grandchildren (Smith & Hancock, 2010).

The quality of grandparents’ lifestyles is greatly complicated by crowded dwellings, with many grandparents receiving some type of public assistance or housing accommodation. Others report that they have a functional disability or other health problems that may be exacerbated by the added responsibilities that accompany raising young children or dealing with adolescents (Fuller-Thomson & Minkler, 2003; Fuller-Thomson & Minkler, 2005; Minkler & Fuller- Thomson, 1999). Some of these middle- aged and older adults experience depression and grief about the loss of their dreams and plans for how to spend their middle age or retirement years. There is also a resulting decrease in the number and type of social outlets they have available, as well as a strain on their marriage after taking on the responsibility of raising a grandchild (Hansard & McLean, 2001).

Even though there are situations such as serious illness or death of the parents in which the grandparents assume care of their grandchildren (Joslin, 2000a), the grandparents may unwittingly pass on to the next generation the very problems that rendered the parents incapable of caring for their children.

In spite of these concerns, many custodial grandparents express delight in being able to participate so closely in the growth of their grandchildren. This attitude is conveyed more by those grandparents who have more education and an awareness of developmental expectations (Giarrusso, Silverstien, & Feng, 2000). Others acknowledge that they are grateful that they have another opportunity to parent and improve upon their parenting. Although the circumstances surrounding the grandparents assuming care of their grandchildren are complicated, many grandparents do appreciate the

reciprocal nurturing that is so necessary for these children, many of whom have experienced substantial chaos or trauma in the transition from their parents’ home (Connealy & DeRoos, 2000; Fuller-Thomson, 2005).

Consider the following example of a grandmother who is raising her adolescent granddaughter, which exemplifies many of the aforementioned issues that custodial grandparents face. Note that the specific identifying features of this case have been changed to preserve the anonymity of the family.

Mrs. H. moves slowly, walking with a cane, as she enters the counselor’s office. Her 14-year old granddaughter, Helena, saunters in with an air of indignation at the very idea of seeing a counselor. Mrs. H. describes her family and the difficulties she has parenting and even communicating with her granddaughter. For the past year, Mrs.

H. has been raising Helena, whose father has been in and out of psychiatric hospitals, having been diagnosed with schizophrenia. The whereabouts of her mother, who has had a history of drug abuse, are unknown. Mrs. H. confides that her deceased husband was mentally ill and she fears that her granddaughter may be like her son and her deceased husband. Consequently, she has been very protective and restrictive with her granddaughter’s activities and friendships. She reports that she has been on disability since her accident at work three years ago. She is now at retirement age and lives in an apartment complex for retired individuals with disabilities. She is concerned about the management of the apartment complex finding out that Helena is living with her since this retirement community has age and disability restrictions.

The school counselor has referred Helena and her grandmother to counseling due to Helena’s belligerent

behavior with teachers and her classmates and a recent decline in her grades. Mrs. H. is concerned about Helena sneaking out late at night to hang out with some new friends that she has made since she began high school. Mrs. H. also thinks that Helena is showing some behaviors that her son exhibited as a teen before he had his first schizophrenic episode, particularly the belligerence and unwillingness to talk about what is upsetting her. Mrs.

H. is not aware of all that Helena has experienced in the tumultuous life that she had with her parents and Helena refuses to discuss it with her.

This case exemplifies the typical challenges that many custodial grandparents face, including: the reasons that Helena is living with her grandmother, the impact on Mrs. H’s life stage needs and lifestyle, the complications of Mrs. H.’s disability and living arrangements, Helena’s behavior at home and school showing effects of living in a chaotic situation with her parents, and her exasperation with her grandmother’s restrictions on her social life. To complicate this situation, Mrs.

H. lacks an understanding about the effects of the trauma that Helena may have experienced, exacerbating the struggles she has with Helena in setting appropriate limits and being able to communicate effectively with her. Mrs.

H. has sufficient resources for her retirement, but these are inadequate for handling the financial and educational needs of a young adolescent. Not only is it important for the counselor to consider Helena’s earlier experiences and the parenting problems, but also it is necessary to address Mrs. H’s life- stage concerns. Counseling can help the grandmother explore ways to connect with Helena. Both Mrs. H. and Helena can learn new ways for Helena to manage her need for safety and autonomy

###### Life-Stage Needs of Grandparents

Considering the developmental needs and expectations of people during and after mid-life or retirement stages, raising grandchildren certainly poses challenges. Life span theories do not address the assumption of parenting responsibility during middle age or late adulthood or the role transitions involved in raising grandchildren (Pinson-Millburn, Fabian, Schlossberg, & Pyle, 1996).

Erik Erikson (1963) considers these adult stages to encompass a search for meaning, an achievement of a sense of integrity and wisdom, and a time for integration. Havighurst (as cited in Cox, 2000) views these later years as an adjustment to limitations and loss due to changes in health, physical strength, and reduced income. Levinson (as cited in Cox, 2000) finds that people at mid- life and late life experience meaningful transformations and increasing awareness of their needs.

Consequently, they make adjustments to their lifestyle to accommodate the shifts in their perspectives and insights about what they deem to be important. For most middle aged and older adults these later life stages involve introspection and integration about the vicissitudes of life. Therefore, custodial grandparents may be vulnerable socially and psychologically since they are out of sync with the expected tasks of their life stage. They may not have time for the personal reflection upon life’s meaning that their peers are relishing as they are making this transition in their grandparenting role (Cox, 2000). In spite of these problems, many look at the responsibility as an opportunity to improve upon an earlier stage, “to do it right” (Connealy & DeRoss, 2000). Now they may have the experience, skills, wisdom, and time to nurture their grandchildren in a manner in which they were unable during their young adulthood when

they were parenting their own children. They see this grandparenting opportunity as a pathway to achieve enhanced feelings of self-esteem and personal control (Cox, 2000, p.9; Edwards, 2000).

###### Grandparenting Styles

Grandparents typically prefer to have a voluntary, non-parental relationship (particularly regarding discipline) with their grandchildren. The variety of roles and styles that grandparents have in their interactions with their grandchildren are dynamic and often overlap (Shore & Hayslip, 1994). Grandfathers often have a more formal style in showing their authority and experience from various life endeavors. They also find joy in providing care for their grandchildren, imparting family wisdom and special skills, and being involved in their grandchildren’s growth and accomplishments. Most of all, grandparents enjoy having a fun and playful relationship, one in which they do not need to exert much disciplinary control (Kopera-Frye & Wiscott, 2000; Neugarten & Weinstein, 1964).

A style in which grandparents are benevolent, but rather distant or remote is rare (Kopera-Frye & Wiscott, 2000; Neugarten & Weinstein, 1964). These distant grandparents may experience more stress if they assume the role of custodial grandparents, whereas those who report frequent involvement with their grandchildren may experience a “good fit” in their parenting role and with less stress (Giarrusso, Sliverstien, & Feng, 2000). Even though most grandparents prefer to have a fun-seeking role with grandchildren, when events compel them to take the responsibility of raising their grandchildren, most do so with genuine concern for the childrens’ well-being (Kopera-Frye & Wiscott, 2000). Some of these custodial

grandparents themselves even report being raised by their own grandparents. Thus their personal experiences and models of parenting and family life have included much involvement with extended family members (Crowther & Rodriguez, 2003).

###### Intergenerational Issues

When family circumstances necessitate that the grandparents take over the custodial parenting responsibilities, there are intergenerational dynamics that significantly impact the grandparents, their adult children, and the young children who need their nurturance and custodial care. The type of relationship that grandparents typically have had with their grandchildren is transformed when they assume parental and limit-setting roles with their grandchildren (Edwards, 2003).

For example, often grandchildren communicate more openly with their grandparents than they would with their parents. This interaction style changes when their once playful or “wise” grandparent now sets limits and provides parental structure and discipline. Children who have been uprooted from their parents’ care may displace their anger, resulting from the trauma and dissolution of their family life, onto their grandparents. The children often have a plethora of emotions resulting from the upheaval in their family life, such as sadness, confusion, frustration, anger, anxiety, and fears about their future (Edwards, 1998; Smith, Donnison, & Vachahasse, 1998). At times, they worry about who will care for them in the event of their grandparents’ failing health or even death (Edwards, 2003). As the children mature, they become increasingly more appreciative of their grandparents’ sacrifices, wisdom, and nurturance (Kopera-Frye & Wiscott, 2000).

For the grandparents, there is also a myriad of emotional and relational changes. Even though they treasure the involvement with their grandchildren, at times they grieve the loss of contact with their friends, their cohort group, and their former “freedom lifestyle” (Marx & Solomon, 2000; Selzer, 1976). The process of “encore” parenting, particularly with children who have experienced trauma, loss, and family chaos, may also place strain on their marital relationship.

Another potentially devastating issue for these grandparents is that they may feel that they have to “destroy” their own child in their attempts to protect their grandchildren. They are angry at times with their own adult children for not being responsible and adequately caring for their children (Edwards, 2000). Custodial grandparents feel somewhat disconnected from their other grandchildren in not having the flexibility to spend quality time with them (Shore & Hayslip, 1994). In spite of these difficulties, these children are more likely to be in a more stable living situation and to eventually be reunited with their parents than children who are placed in foster care (Solomon & Marx, 1995), as cited in Pinson- Millburn, Fabian, Schlossberg, & Pyle, 1996.

###### Strengths and Resources of the Grandparents

In spite of the many challenges that middle-aged and older adults may face when caring for young children and adolescents, there are strengths that emerge in the process of raising their grandchildren. Depending upon their financial circumstances and work responsibilities, they may have more time and emotional sensitivity to invest in their grandchildren. In addition, they offer a lifestyle that may be more

stable, consistent, and safe than what the children have previously experienced. These grandparents often demonstrate a willingness to pursue varied enriching experiences for their grandchildren. Since they are not investing in acquiring material assets, they have flexibility to use their resources to provide opportunities that their grandchildren may not have otherwise received, although at times at the expense of their retirement income and savings (Fuller-Thomson, 2005; Hayslip, Shore, & Henderson, 2000).

Ideally, they have a reservoir of interpersonal experiences to use to help them handle troublesome situations with their grandchildren. Their broad perspective provides them with the ability to ascertain what is most critical for limit setting with young children and teens. Thus, they may be more likely to pick their battles judiciously if they have had the life experiences and the emotional stability that renders them capable of doing so.

These resilient grandparents emphasize that the reciprocal loving relationship that they experience is one of the positive outcomes of being able to have such a significant part of their grandchildren’s development. They also feel a great deal of relief in knowing that the children are in a safe place (Fuller-Thomson, 2005). This may be particularly crucial to them if they have had extended conflict about foster placement issues involving the parents and the courts.

Older adults are more likely to have a deep and mature spirituality. They rely on this spirituality to help them navigate through tough times (Musil, Schrader, & Mutikani, 2000). This quality may even deepen their grandchildren’s faith and feeling of connection. Many grandparents view their role in caring for their grandchildren as a gift in that they have renewed motivation to take better

care of themselves. In this process of improved self-care, they develop strategies to buffer the needs of the children and the demands on the children from school, peers, and other outside forces (Giarrusso, Silverstein, & Feng, 2000). There are numerous examples of the grandparents becoming strong advocates for the children and becoming involved in the community and the neighborhood schools (Edwards, 2003; Woodworth, 1994).

This investment of their time and energy renews their vision and hope for the future of their grandchildren.

Overall, raising younger children who are not exhibiting behavioral problems at school seems to have a positive effect on the grandmothers’ health as well as enhancing the grandfathers’ sense of family connection (Marx & Solomon, 2000).

###### The Concerns of Custodial Grandparents

Grandparents who take on the challenge of raising their grandchildren gradually realize that there are many obstacles in this sometimes ambiguous undertaking. Many encounter a confusing array of legal issues regarding custodial rights of their grandchildren. They may be in a quandary about which options they should choose regarding guardianship, healthcare, and disability assistance, not only for themselves but also for their grandchildren (Cox, 2000).

Their housing situation may need to change, particularly if they are living in a neighborhood or housing development with restrictions related to residential age or disability. As a consequence of this, they may need to move and have the additional difficulty of securing affordable housing suitable to their fixed income status (Fuller- Thomson & Minkler, 2003). Obtaining some financial support may be necessary, but there are few programs

available to grandparents who have full responsibility for their grandchildren (Cox, 2000; Fuller-Thomson & Minkler, 2000a).

They may also sacrifice their own physical and psychological healthcare in order to provide healthcare for the children. Consequently, securing adequate mental and physical heath care may not be easy or within their financial reach. To complicate this matter, the grandparents may have compromised their own health due to age related ailments and the added stress of child care (Minkler & Fuller- Thomson, 1999). They often express dismay at having less physical energy to keep up with the demands of caring for young children. In spite of these expressed concerns, they either minimize or do not dwell on these matters, partially due to fears that admitting hardship may lead to the children being placed in foster care or returned to a dysfunctional situation with their parents (Cox, 2000; Edwards, 2000).

These grandparents also express that they experience difficulty communicating with school administrators and teachers regarding their grandchildren’s educational needs (Musil, Schrader, & Mutikani, 2000).

Since they have not been or have never been involved with an educational setting in at least a decade or longer, they feel out of touch with how schools function or the types of instruction that are currently used. They need assistance in working with the school regarding their grandchildren’s academic achievement and social development. Being able to handle the behavioral, emotional, and learning problems that their grandchildren may be exhibiting is yet another concern that many grandparents identify (Edwards, 2003).

Grandparents who are raising grandchildren also are out of sync with

their life stage and the activities of their friends. They may lack the social support and connections with their peers that are crucial in helping them cope with this challenging endeavor (Marx & Solomon, 2000; Shore & Hayslip, 1994). They express frustration with the lack of on-going support services, such as respite care or affordable baby sitting services to give them some reprieve from the parenting responsibilities (Fuller- Thomson & Minkler, 2000b).

###### Concerns of the Grandchildren

The children also bring up their concerns and issues regarding living with their grandparents. Not only do they feel confused about their living situation and disenfranchised from their parents, they also are angry and resentful at their grandparents’ attempts to restrict or set limits on them. This may be an abrupt shift from the type of relationship they previously had with their grandparents. There are a variety of emotions that these children experience: embarrassment about living with grandparents, grief or internalized guilt for “causing” their parents to give them up, and detachment from their caregivers. Elementary school age children and young adolescents may complain about their grandparents’ physical and financial limitations and they have difficulty empathizing with their grandparents’ challenges (Strom & Strom, 2000). Frequently though, as they mature, they become more appreciative, helpful, and empathic towards their grandparents (Dolbin- MacNab, Rodgers, & Traylor, 2009). In fact, they may be the very family members who are likely to provide assistance and care for the grandparents as they navigate through very late adulthood (personal

communications with former clients, 1998 through 2002).

Another issue that frequently surfaces as the children continue to live with their grandparents is that of loyalty conflicts toward their grandparents, parents, and other relative caregivers. They experience confusion and frustration in having to grapple with the changing expectations of their different living situations. This continues even after they reach young adulthood in their attempts at navigating through these and other intimate relationships (Dolbin-MacNab, Rodgers, Traylor, 2009). These children, who are at times antagonistic toward their grandparents, eventually develop a strong attachment to them as the grandparents provide consistent nurturing that they desperately need.

As the children come to depend on and trust in their grandparents’ care, they also fear that their beloved grandparent(s) will become very ill or die (Edwards, 2003).

These concerns have been reported in a number of studies of custodial grandparents and observed by the author through counseling and talking with members of “grand families.” School counselors, teachers, school administrators, and mental health professionals identify these concerns when they are called upon directly by the grandparents or the children, or referred through some contact with a social service agency, or by the school officials (Edwards, 2009).

###### Challenges for Counselors

Even though grandparents who are raising their grandchildren experience many difficulties, they may be reluctant to seek assistance from counselors for family or personal concerns. They are often fearful about exposing the situation and confused about the complex custody issues (Musil,

Schrader, & Mutikani, 2000). Grandparents with health complications are more likely to be raising grandchildren with neurological, emotional, behavioral, and physical problems. Thus, for many reasons, these families are the least likely to seek and receive counseling services (Fuller-Thomson & Minkler, 2000a).

Another obstacle they face is that it is often difficult to find resources in the community, particularly in rural areas or in small towns. It seems that once the children are placed with their grandparents, many social service resources shrink (Minkler & Roe, 1993; Poe, 1992). Even though grandparents may be the best caregiver choice for the children, they have only recently been recognized as needing a variety of different supportive structures, some of which have typically been provided to foster parents.

When grand families do come to counseling, counselors must triage the various presenting and indirectly related concerns. They also need to determine whom to involve in therapy. Usually, the identified problems involve a complicated mixture of issues and family members. For example, the grandparents experience frustration, anxiety, loneliness, and anger related to the excruciatingly painful witnessing of their own children’s demise from drug abuse (Musil, Schrader, & Mutikani, 2000). At the same time, the grandparents must also deal with the effects of their adult children’s dysfunctional behavior on their grandchildren.

As it is a struggle for the grandparents to seek out mental health agencies that serve custodial grandparents and their children, there is a high drop-out rate from counseling and family therapy with grand families. The reasons vary and include financial challenges, difficulty in accessibility of the agency’s or professional’s offices,

confusion about the counseling procedures, along with physical and mental health complexities (J. F. Orwig, personal communication, January 21, 2010).

Counselors who work with grand families find that many grandparents have complicated mental and physical health problems. Custodial grandparents, particularly the grandmothers, have twice the rate of depression as non-custodial grandparents (Minkler & Fuller- Thomson, 1999). Thus, this “time- disordered role” in their life cycle increases the likelihood of depressive symptoms, especially in younger grandmothers. Research also suggests that caring for grandchildren may be more stressful than caring for an elderly spouse or parent (Giarrusso, Silverstein, & Feng, 2000).

Another often under reported issue is that of elder abuse. Some studies indicate that victims of elder abuse are often those caring for their adolescent grandchildren and adult children. The grandparents fear that the abusive actions toward them will be discovered. They are concerned that the adolescents would then be removed and placed in foster care or that there would be other negative repercussions (Brownell, & Berman, 2000).

Custodial grandparents may initially seek treatment for hypertension, back and stomach pain, insomnia, and other physical disorders, some of which are age related. They often report that their health has been compromised since taking on the duties of childrearing.

Many of the grandparents who take in children as infants or preschoolers are more likely to report difficulty in activities of daily living (Minkler & Fuller-Thomson, 1999). Grandparents who have many health problems are often raising grandchildren who also have physical and behavioral problems (Fuller-Thomson & Minkler, 2000a). In

spite of their reported health problems, these grandparents are less likely to actually seek help for themselves and are more likely to miss their appointments in favor of providing needed health care services for their grandchildren. Even though they need a blend of social services and counseling interventions, these grandparents are less likely to seek out the services or any assistance for themselves (Joslin & Brouard, 1995).

Ironically, those grandparents who are in good health are more likely to access services for themselves as well as for their grandchildren (Fuller-Thomson & Minkler, 2000a).

Experiencing abuse or neglect during early childhood contributes to attachment difficulties with significant caregivers. Grandparents who take over parenting are often confused and distressed by the resulting regressive, immature, and fearful behaviors of their grandchildren. In addition to the mental health issues, the children also have associated physical problems (Marx & Solomon, 2000). Counselors and health professionals have noted high rates of asthma, respiratory problems, fetal alcohol syndrome, sleep difficulties, eating problems, and physical disabilities among many of the children who are being raised by their grandparents (Doucette-Dudman & LaCure, 1996; Edwards, 1998). These problems contribute to frequent absences from school and the associated academic and social disruptions for these children.

The grandparents’ level of education is an excellent predictor of overall physical health and psychological well- being, particularly in taking on parenting responsibilities. In fact, educated grandparents experience more satisfaction and are better able to anticipate developmental milestones or problems. They are adept at selecting mutually fun, healthy, and rewarding activities with their grandchildren (Giarrusso, Silverstein, & Feng, 2000). Therefore, providing information about developmental expectations and a broad range of educational and health information for the grandparents may enhance their coping skills, health practices, and parenting strategies, helping them discover that parenting their grandchildren can be rewarding.

There are other related challenges for counselors who are treating these grandparents, particularly in ascertaining what is best for the children. Conflicting ideas from educators, parents, grandparents, the legal system, human services, and members of the extended family exacerbate the confusion about what and who should be the focus of treatment. A vicious cycle (as shown below) ensues, involving these family dynamics: contextual trauma, the physical and emotional needs of the children and the grandparents, difficulty adjusting in school, defiant or delinquent behavior, academic setbacks, problems living with grandparents, and the strain on grandparents (Edwards, 2000).



Providing counseling for the grandchildren traumatized by the experiences with and separation from their parents requires a sophisticated knowledge about the dynamics and effects of such experiences. Since the children often feel rejected or have experienced interruptions in attachment to their parents or caregivers, they may be less trusting, more defiant, and more likely to use attention seeking or rebellious behaviors (Edwards, 2003).

Counselors must also consider the effects of the multigenerational transmission process. Problems the adult children experienced, as evidenced by their dysfunctional parenting behaviors, are related to patterns of coping with stress from previous generations (Gladding, 2007). The grandparents may be at the same level of emotional maturity and differentiation as their adult children. Therefore, the grandparents may also continue that dysfunctional system with their grandchildren. It is crucial for counselors to assist the grandparents (and parents if available) to explore ways of arresting the dysfunctional patterns of stress management that contributed to the

parenting problems encountered by all three generations.

Grandparents who seek counseling sometimes express their worries about the child being “just like his or her mom or dad.” As a result, they may treat their grandchild like they treated their own child (Brownell & Berman, 2000; Giarrusso, Silverstien, & Feng, 2000). Another dilemma that they face is that the parenting strategies they previously found to be effective do not work with their grandchildren who exhibit the reverberations of early trauma and chaos. They often misinterpret certain behaviors as disobedience, insubordination, or disrespect when they may be reactions to trauma. Consequently, their discipline strategies may escalate the behavioral problems and altercations with their grandchildren. The children construe the limit setting and punishment as being yet another abusive experience (Brownell & Berman, 2000).

Both grandparents and the children experience loss and grief: the grandparents mourn the loss of a relationship with their own adult children, and the children feel rejection and grief from the missing parent(s).

This may be evidenced as depression in

adolescents. As a way of grieving, the teens may lash out aggressively to their grandparents simply because they are accessible. The grandparents, in reaction, become more authoritarian, rigid, punitive, as well as hypervigilent (Brownell & Berman, 2000).

Children need their caregivers to help them restore a feeling of security and safety when they are distressed, and this “mitigates against trauma- induced terror” (van der Kolk, 2005, p. 403). If the grandparents do not know how to respond to their grandchildren’s dysregulated internal state and distressing behavior, then the children cannot understand what to expect or be able to develop appropriate coping skills (van der Kolk, 2005). Therefore, it is important for counselors to provide assistance, reassurance, and strategies to help grandparents cope and successfully parent, as well as to help them understand and recognize the emotional and behavioral effects of trauma, neglect, and the resulting attachment breaks.

Another critical issue concerns the pervasive biological and emotional problems that traumatized children demonstrate. The symptomatic behaviors often yield diagnoses such as: oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder, an anxiety disorder, or even bipolar disorder (Wylie, 2010). Bessel van der Kolk (2005) and members of the National Child Traumatic Stress Network DSM-V task force propose a diagnosis of Developmental Trauma Disorder to be included in the upcoming DSM-V. The term, “complex trauma,” has been used to describe interpersonal abusive events that take place usually during early childhood. These are prolonged or repeated and the chronic nature of these abusive experiences or attachment breaks have profound effects on neurobiological, cognitive,

and emotional development, and the establishment of a healthy and resilient self-concept (Cook, Spinazzola, Ford, Lanktree, et al., 2005). Therefore, counselors need to consider the contextual factors in working with the grandparents, children, and the school. This may require some explanation about the effects of trauma and attachment breaks with all involved so as to prevent treatment focus on symptoms alone.

###### Counseling Implications and Strategies

Giarrusso, Silverstien & Feng (2000) report that raising grandchildren and dealing with the ramifications of the dysfunctional behavior of their adult children to be more stressful than providing care for an aging spouse or parent. Counselors who encourage the custodial grandparents to get involved in educational support programs may help the grandparents cope more successfully with the stresses involved in parenting children and coping with problems of their adult children (Giarrusso, Silverstien & Feng, 2000).

Edwards (2000, 2003) contends that grand families benefit from an integrated approach which involves the following array of services: counseling for the children and grandparents, peer support groups, parent training for the grandparents, use of community resources, legal services, respite care, and contacts with teachers and school counselors by the mental health professionals who are working with the grand families. Culturally sensitive support groups and therapeutic interventions can play a significant role in helping grandparents recognize and build upon their strengths and creatively use their resources to meet their personal and relationship needs that they have been neglecting (Fuller- Thomson & Minkler, 2000a).

Leder, Grinstead, Jensen, & Bond (2003) conducted an archival study of psychotherapeutic treatment outcomes for children living with their grandparents. They found that children who had regular contact with their father or had grandmothers with adult partners had better outcomes in getting along with others, using free time, and developing positive attitudes towards themselves. The grandparents of these children also were counseled to be consistent in using discipline strategies. These researchers recommend that for the best outcomes for both the children and the grandparents, counseling needs to be initiated when the children are very young or as soon as the grandparents take over as the primary caregivers.

Edwards (2000) advocates for a preventative approach in helping not only with those children in grand families who are at risk for academic problems, but also those who are performing well. Edwards & Mumford (2005) suggest that these families need a multi-faceted approach including mentoring, counseling, support groups, and parenting classes specifically geared for the grandparents.

Although many reports from clinical practices have not shown significant treatment outcomes “researchers agree that the most effective and empirically supported treatments for oppositional behaviors and conduct problems are based on parent-training models, with cognitive-behavioral skill-training models also showing probable efficacy” (Silverthorn & Durrant, 2000, p. 52).

Silverthorn & Durrant describe the following four parent training models: Parent-Child Interaction Therapy by Hembree-Kigin & McNeil, 1995, Helping the Noncompliant Child by Forhand & McMahon, 1981, Defiant Children: A Clinician’s Manual for Parent Training by Barkley, 1987, and Parents and Adolescents Living Together by

Patterson & Forgotch, 1987. All of these models focus on teaching parents play and discipline strategies that incorporate being consistent, establishing reasonable rules and following through with consequences, effectively using time-out, and praising and reinforcing compliance and other positive behaviors. Parents and Adolescents Living Together also includes teaching the parents and teens negotiation skills that consider the adolescents’ need for increasing independence.

Approximately 88% of custodial grandparents are raising pre-school and elementary aged children, and it seems that these parent training models would be the most relevant choices for counselors to use with grand families (Silverthorn & Durrant, 2000). Even though these popular parent-training models are often used with parents of children who have been diagnosed with disruptive behavior disorders, there is little research on the use of parent management models with custodial grandparents. In addition, the grandparents may experience difficulty actually implementing these parenting strategies because their grandchildren have problems resulting from a complicated mixture of disruptive events in their lives.

Recent studies on the treatment of children who have experienced trauma and attachment breaks are showing promising results. This type of assistance could be expanded to be used with grandparents and the children in helping them understand the effects of trauma and attachment breaks and in using calming strategies with their grandchildren. Blaustein & Kinniburgh (2007) explain the importance of moving beyond the focus on treating the disruptive and inappropriate behaviors:

Often, interventions for children who have experienced trauma target

the posttraumatic symptoms while neglecting the larger caregiving system and the array of impacted developmental tasks. Given the frequent overlay of trauma exposure in childhood with disrupted attachment, it is crucial that interventions go beyond the specific posttraumatic sequelae and prioritize interventions that increase the capacity of the caregiving system to support healthy development (p. 49).

The studies on interventions for children who have symptoms of the aforementioned proposed developmental trauma disorder (DTD) or display effects of complex trauma have been promising. Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET) is an intervention for preadolescents and teens developed by Julian Ford at the University of Connecticut Health Center and one of the coauthors of the DSM-V proposed DTD. The focus is on assisting youth and their families in understanding how the trauma they experienced impacts their responses to various events that trigger unsettling emotions. They learn about how the trauma affects their entire nervous system and counselors teach them ways to soothe themselves and to identify and use their inner resources. Acquiring these coping strategies builds their confidence in their resiliency and ability to stabilize their emotions and behaviors when they perceive an interpersonal threat (Ford & Saltzman, 2009; Wylie, 2010).

Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth (ARC) is another promising model that focuses on working with the caregivers of children who have experienced sexual and physical abuse. This intervention is a phase oriented approach in helping the caregivers develop secure attachments with their grandchildren

and learn ways to help the children regulate their emotions, be soothed, and eventually learn to self soothe (Blaustein & Kinniburgh, 2007; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Another aspect that makes this treatment approach appealing to many counselors is that it is based on strengths of the family system and the children in that system. Developing ways to build safe interpersonal connections among the family members and intrapersonal feelings of safety within the members is accomplished through the use of various strategies that address ten intervention targets within the domains of attachment, self-regulation, and competency. This model is well suited for using with grand families because the attachment domain “targets the child’s caregiving system” (p.50), whether the caregivers are parents, relatives, foster parents, or grandparents (Blaustein & Kinniburgh, 2007). Grandparents would also appreciate the emphasis on their strengths, wisdom from their experiences, resources, and resiliency.

###### Summary

The trend in using kinship care systems for children, who for a variety of reasons cannot live with their parents, most likely will continue. The recent attention to the benefits and problems inherent in grandparents raising their grandchildren has shown that there is much to be gained from exploring ways to help this type of caregiving system. Counselors and family therapists have noted the challenges that these older adults and children face in coping with this profound upheaval in their family life and development. There needs to be creative integration of parent training approaches with therapy models that target treatment of the developmental

problems associated with complex trauma and attachment breaks. This treatment can coordinate with the grandparents’ attempts at managing and nurturing their grandchildren. The typical parent training models for children with behavioral problems are insufficient in assisting grandparents and the children in dealing with the trauma and chaos they have witnessed.

A plethora of research about the developmental and neurological impact of trauma has provided an abundance of information that mental health professionals did not have to draw upon 15 years ago in working with traumatized children or their kinship care systems. Currently, the strategies associated with the recent findings from developmental neuroscience and studies of the developmental impact of experiencing early trauma can be investigated as possible therapy approaches for grandparents and their custodial grandchildren.

In addition, there has not been research on the long-term effects on children who have been raised by their grandparents as they move into adulthood, nor has there been much outcome research on specific counseling interventions with the children who are living with their grandparents. These two very important areas for further investigation would provide direction for helping professionals who counsel these grand families and validation for the grandparents and the young adults who have been raised by their grandparents. Considering the extent of custodial grandparenting, this research is an important step that can also assist this generation of grandchildren as they begin their own families.

Studies during the past 20 years have clearly shown that family life has transformed from the nuclear family to a variety of kinship combinations.

There is an abundance of information about the issues involved in the process of grandparents taking over the parenting role. What is needed now are studies that investigate counseling strategies that would be most beneficial for these families, considering the contextual nature of the custodial grandparent arrangement rather than the focus on symptoms alone. There are many questions that research projects can explore: What have the grandparents learned about nurturing children from their experience with their now adult children? What are ways that counselors can facilitate a change in the intergenerational transmission of coping patterns so that the next generation can effectively establish healthy intimate relationships within these grand family arrangements? How can grandparents use their strengths and resources to build healthy bonds with their grandchildren and effectively assist them in grappling with the trauma they have experienced? What have the adult grandchildren gained from living with their grandparents that they want to share with their own family of procreation? What are the specific difficulties that the adult grandchildren experience in their relationships that are related to being raised by their grandparents? The findings that address these questions will certainly provide a dynamic boost for these grand families as well as the educators and mental health professionals who work with them.

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# Section II: Student/Professor Articles

## Counseling Young People with PTSD

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PTSD is a prevalent and significant disorder that affects the lives of many youth. Targeted interventions should address both the symptoms of PTSD as well as the precursory events that lead to the diagnosis. Counselors should be aware of the many possible sources of traumatizing events such as threats of death, sexual abuse, severe neglect, and environmental factors (e.g., hurricanes/tornadoes). This article informs counselors of the prevalence of PTSD, treatment options and characteristics of PTSD in children and teens.

###### Introduction

Children and adolescents can be traumatized in a great many ways (Henderson & Thompson, 2011).

Malchiodi (2008) noted that throughout human existence, every generation has been challenged by its share of war, pestilence, famine, plague, murder, and rape. Adults left to their own devices can struggle to make useful meaning from such horrific events; children and adolescents, with limited cognitive, emotional and psychological resources, can have a much greater challenge in understanding what happened and how to best respond. Professional counselors in the role of helping children and teens should be prepared to recognize, assess, and treat kids suffering from the devastating impact of trauma.

In modern times, Cook-Cottone (2004) found that “as many as 25% of all children experience a traumatic event by the time they are 16 years of age” (p. 127). Although some children

survive and even flourish after experiencing a traumatic event, in some instances, children and adolescents exhibit a variety of symptoms resulting from the trauma that can significantly disrupt their lives and impair their development (Henderson & Thompson, 2011). It is estimated that 30% of traumatized children and adolescents may develop thoughts and behaviors that meet the diagnostic criteria for clinical PTSD (Cook-Cottone, 2004).

This article provides information for practitioners to utilize to effect positive change in the lives of youth suffering from PTSD.

###### Disorder and Criteria

The first time that *The Diagnostic and Statistical Manual of Mental Disorders* made any reference to diagnosing a traumatized child was in 1987 (Lubit, 2010). However, both prior to inclusion in the DSM and since this official classification took place, a

substantial number of studies have been conducted to examine the effects of trauma on children and adolescents. Today, *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, offers clear diagnostic criteria to help clinicians identify children suffering from PTSD.

Diagnostic Criteria

Childhood PTSD includes experiencing, witnessing, or being confronted with a traumatic event involving either death or the threat of such, the threat of extreme physical violence, or witnessing death or violent injury (APA, 2000). To meet diagnostic criteria, the child’s reaction to the event must include a sense of horror, feeling helpless or experiencing intense fear (this may be expressed as disorganized or agitated behavior in children).

In diagnosing PTSD, differentiation must take place between experiencing something traumatic and having cognitive/emotional/behavioral reactions to the event *after* the initial threat has subsided. For example, an individual with PTSD will have symptoms that include re-experiencing the traumatic event recurrently and intrusively. The recurrence may be manifest in thoughts and images, recurring dreams, and/or reliving the event. Additionally, distressing recollections may be expressed through repetitive play. In such play, themes of the trauma may surface. The child’s recurring dreams may contain disturbing and/or unrecognizable content. In some cases, the child may experience a pervasive sense of numbing which can cause avoidance of stimuli that may remind him or her of the event. Behavioral indicators (when the child is in the presence of such stimuli) might include problems with sleep, being over-vigilant, irritable, and/or easily startled. These symptoms

must be present for more than a month and cause *clinically significant distress* or impair the individual’s ability to function in a social setting, at work, or in other areas. The ailment is specified as ***acute*** if the symptoms are present for less than three months and ***chronic*** if present for three months or more. In the event that the symptoms are NOT PRESENT for more than one month, the diagnosis is Acute Stress Disorder (ASD), a short-term condition that under fortunate circumstances can be resolved in less than 30 days. Of course, in the event that ASD is not accurately diagnosed and treated, it may turn into a diagnosis of PTSD (APA, 2000).

Examples of traumatic events vary from client to client. However, predominant precursors include child sexual abuse, domestic violence (Cook- Cottone, 2004) or naturally occurring events, such as tornadoes and hurricanes. For instance, a study of youth survivors of Hurricane Katrina conducted by Pina et al. (2008) found that nearly 24% of those studied met criteria for PTSD. Other forms of trauma may include rape, witnessing a car accident, suffering from a gang- related attack, or witnessing the death of a stranger.

Triggers and re-triggers to PTSD can be experienced from a distance.

Although physically distant, for some youth, traumatic events that have been learned can have negative influences.

For example, witnessing the Challenger disaster or the fall of the World Trade Center towers on television can surface PTSD symptoms or resurface traumatic events that previously had been left untreated (Cook-Cottone, 2004).

Structural Changes in the Brain

Studies using magnetic resonance imaging (MRI) have found abnormalities in the brain structure of

individuals (both adults and children) with PTSD (De Bellis et al., 1999; Jackowski et al., 2009). In a study comparing children and adolescents diagnosed with PTSD with a matched control group, De Bellis, et al. (1999) found smaller mid-sagittal areas of the corpus callosum in PTSD sufferers, while the lateral ventricles were proportionately larger (Figure 1).

Jackowski et al. (2009) also found that images of children with PTSD revealed a corpus callosum that was smaller than normal. Given the association between damage to the corpus callosum and behavioral problems in perception, comprehension, and response, De Bellis et al. (1999) suggest that the symptoms of dissociation and difficulties in executive function associated with PTSD might be explained by these changes.

**Figure 1.** MR images comparing lateral ventricles in 11-year old with chronic PTSD (right) to healthy matched control subject (De Bellis, 1999).

Children suffering from PTSD may also have symptoms for other disorders, including phobias, inappropriate sexual behaviors, generalized anxiety disorder, depression and behavioral problems (King et al., 2003). As might be expected, these additional problems can make

treatment of PTSD increasingly complex. PTSD in children may be misdiagnosed as ADHD, Oppositional Defiance Disorder, and/or Conduct Disorder. Further, self-treatments may include the use/abuse of substances (drugs/alcohol), self-injuring, anti social behaviors, and acting out.

As Cook-Cottone (2004) noted, the trauma suffered may be time- limited (e.g., a rape, shooting, or natural disaster) or it may be cumulative (e.g., chronic incest, war, or ongoing catastrophic illness). In cases where the trauma is cumulative, each successive incident may leave the child increasingly vulnerable.

###### Assessments

There exists a wide variety of appraisals to assess for trauma and PTSD. Many of these instruments can be used for individuals from 4-years old to adult. Assessments include self- reports, parent/guardian reports, and both structured and semi-structured interviews. Cook-Cottone (2004) lists 20 psychometrically evaluated tools useful in assessing PTSD symptoms among children and adolescents. Foa, Johnson, Feeney, and Treadwell (2001) noted that one of these, the Child Post- Traumatic Disorder Reaction Index (CPTSD-RI), although satisfactory psychometrically, was limited in measuring PTSD severity; while a newer instrument, the Child PTSD Symptom Scale (CPSS), links directly to the symptoms of PTSD, suggesting that it is a more useful tool for assessing severity of the disorder. Another PTSD instrument, the My Worst Experience Scale (MWES), a self-report questionnaire designed for use with ages 9-18, was described by Medway (2005) as well-constructed and especially useful in identifying symptoms associated with stresses from school and community sources.

Among the PTSD instruments listed by Cook-Cottone (2004), only one, the Traumatic Event Screening Inventory – Child Version (TESI-C) is intended for young children under the age of six. In reporting on a number of newer instruments intended to assess PTSD and potentially traumatic events among individuals in this age group, Stover and Berkowitz (2005) found that the Preschool Aged Psychiatric Assessment (PAPA) and Trauma Symptom Checklist for Young Children (TSCYC) exhibited promising psychometric properties, but required further development and should not be relied on for a definitive diagnosis.

Although useful, further research, especially in the area of developing tests that incorporate both parent/caregiver reports with direct observation of the child is required to make such instruments more effective.

###### Treatments

A number of treatments have been used to effectively treat trauma and PTSD. Valentine (2002) reports a number of modalities that have been researched, including “cognitive processing, prolonged exposure, hypnosis, systematic desensitization, flooding, supportive counseling, stress inoculation, assertion training, group, and eye movement desensitization (EMDR) (Valentine, 2002, p. 257).

Feeny, Zoellner, Mavissakalian, and Roy-Byrne (2009) report that, along with psychotherapy, the antidepressant sertraline, a selective serotonin reuptake inhibitor (SSRI), is sometimes efficacious in treating PTSD.

There are various theoretical approaches and techniques used to treat PTSD in children and adolescents. The counseling theories described in this article are merely examples of some evidence based approaches found effective. However, as reported by Botella et al. (2010), the treatment of

choice for PTSD is generally considered to be some form of Cognitive-Behavioral Therapy (CBT).

One such variation of CBT that uses exposure and cognitive therapy has found to be effective with adult sufferers, especially Vietnam veterans and rape victims (Botella et al., 2010). Similar interventions have been successfully adapted for use with children. In such a treatment approach, the child is taught effective coping skills to provide a positive way to overcome troubling emotions that arise from the abuse. Additionally, the child is taught social skills as a means to overcoming withdrawal from social contact or aggressive behavior tendencies. Graded exposure is used to help the child gradually and systematically overcome stress inducing stimuli. Children dealing with past sexual abuse learn about protective behaviors, healthy sexuality, body ownership, when and what forms of touching are OK and not OK, and the right to say, “No!” Role play along with other psycho-educational techniques can be used to teach personal safety skills to help children respond appropriately to inappropriate sexual advances.

Another form of treatment reported by Grasso et al. (2009) as having the most empirical support for children with PTSD is called trauma- focused cognitive behavioral therapy (TFCBT). According to Feather and Ronan (2009), TFCBT is a four-phase program provided over the course of 16 sessions. The first phase addresses relationship issues and contextual/environmental factors.

Focused attention during this phase includes developing social supports and overall psychological well-being. The second phase focuses on anxiety issues utilizing a CBT format to identify and replace counterproductive thought patterns. The third phase utilizes gradual exposure techniques “derived

from behavioral, cognitive and expressive therapy models” (Feather & Ronan, 2009, p. 178) to help process and resolve trauma issues. Finally, Phase 4 provides the means for the individual to transition out of therapy and back into life through development and adherence to a relapse prevention plan.

Adler-Nevo and Manassis (2005) suggest the use of play therapy as yet another method for treating childhood PTSD. Through symbolic play, the child revisits the troubling past traumatic event in a safe, supportive and trusting setting. During this process, the child restructures their thoughts, emotions, and senses to better cope with the present and future. Additionally, play therapy offers the child an opportunity to play through the trauma metaphorically (which is dissimilar to re-living the traumatic event) in a way that they can make meaning from the experience and decide on a new ending to the story.

A pilot study conducted in the United Kingdom by Stallard, Velleman, & Baldwin (2001) found that childhood victims traumatized by road traffic accidents were often helped by simply being afforded the opportunity to talk about the accident and, thereby, feel understood. In other words, given the right circumstances, providing the child with an opportunity to talk about the accident may be enough to prevent or reduce their distress. This is especially true in cases where the child has not yet reached a highly traumatized state.

Not to be overlooked in the treatment and healing process for kids suffering the effects of traumatic experiences is the concept of *resiliency.* Surfacing from within the child, resiliency is considered a complex internal process that promotes health and the overcoming of extreme conditions (Henderson & Thompson, 2011; Arbona & Coleman, 2008).

However, though considered an internal function, current research indicates that resiliency comes from “human resources in the minds, brains, and bodies of children, in their families and relationships, and in their communities” (Masten, 2001, p. 235).

Therefore, clinicians working to utilize children’s resiliency should capitalize on positive environmental, societal and familial resources.

Resiliency in kids with PTSD helps them overcome fear, stress, and anxiety. This process is accomplished through meaningful relationships (Luther, 2006), looking for positives in life rather than focusing the counseling on problems or negatives (Rak, 2001), and through creating a clinical environment that encourages kids to utilize their natural skills in problem- solving and behavior modification.

###### Resources

There are a considerable number of current books and web sites devoted to helping professional counselors to both understand and treat PTSD. In the book, *Treating Trauma and Traumatic Grief in Children and Adolescents,* Cohen, Mannarino, & Deblinger (2006) provide direct, clear and concrete examples of how to use cognitive behavioral therapy in effectively treating traumatized children. Another book that provides pragmatic approaches to counseling children suffering from PTSD is *Creative Interventions with Traumatized Children.* The author, Malchiodi (2008), suggests incorporating expressive art approaches such as music and drama to support the recovery process. Additionally, Nickerson, A., Reeves, M., Brock, S. & Jimerson (2008) in their book, *Identifying, Assessing and Treating PTSD in School,* have provided a text written for school practitioners that targets not only treatments for children with PTSD, but also suggests effective

ways to recognize PTSD in school children.

###### Summary

Children and teens face numerous stresses and strains as they transit from youth to adulthood.

Although PTSD may seem like a disorder that should escape the innocent age of childhood, it is well documented that children and adolescents are also susceptible and at times, have been misdiagnosed or untreated. Unfortunately, trauma and traumatizing events are all too common in the world, whether due to natural causes or the depraved hand of a child sexual abuser. In order to help the children suffering from this pernicious disorder, it is necessary for professional counselors working with youth to learn about PTSD’s causes, symptoms, and treatments in order to overcome their traumatic events and reach their true potential.

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## Study Questions for Licensed Professional Counselors

##### A score of 100% is needed on the following items. Once scored, you will receive a certificate verifying **2.5 Continuing Education Clock Hours.**

Continuing Education Questions for Soldier Article:

1. Students in this study indicated that there were several barriers to veterans’ access of mental health services on college campuses. Which of the following is **NOT** a barrier that was mentioned?
	1. Financial stressors
	2. Time constraints
	3. Individual differences such as age, gender, and culture
	4. Social stigma
2. The majority of student respondents in this study believed that which of the following mental health professionals is most qualified to provide counseling services for veterans?
	1. Licensed Professional Counselors
	2. Psychologists
	3. Social Workers
	4. Psychiatrists

Continuing Education Questions for Grandparent Article:

1. The author mentions several concerns of custodial grandparents which might create difficulty in caring for their grandchildren. Which of the following is **NOT** one of the concerns mentioned?
	1. Financial and housing difficulties
	2. Lack of adequate attention to their own physical and psychological well being
	3. Difficulty identifying with the grandchild’s friends
	4. Difficulty communicating with the grandchild’s school administrators and teachers
2. What are some difficulties that counselors who work with “grand-families” experience?
	1. Difficulty in deciding which individuals/family members should receive counseling
	2. Confusion at the overabundance of community resources available for grand-families
	3. High dropout rate of grandparents and grandchildren
	4. Both A and C

## Credit Verification Form for Licensed Professional

Counselors

The Louisiana Counseling Association awards **2.5 Continuing Education Clock Hours** for reading the *Louisiana Journal of Counseling (LJC)* and correctly completing the Study Questions. To receive a certificate verifying your participation in this easy and inexpensive way to earn valuable continuing Education Clock Hours, complete the form below and mail it, **along with $10 and your completed study questions**, to the following address:

###### Diane Austin

**LCA Executive Director 353 Leo Street**

**Shreveport, LA 71105**

I verify that I have read the entire **FALL 2011** edition of the *Louisiana Journal of Counseling (LJC)* and am now applying for **2.5 Continuing Education Clock Hours** in conjunction with correctly answering the Study Questions for this year’s journal.

**Name** (PRINT – as you wish to have it appear on your certificate):

###### Mailing Address

Street

City State Zip

**Phone** (cell) (other)

###### E-mail

**Signature**

**Date**

\*Make checks payable to **LCA**

A Verification form with your clock hours will be mailed directly to the address provided on this form.

# GUIDELINES FOR AUTHORS

##### The *Louisiana Journal of Counseling (LJC)* publishes articles that have broad interest for a readership composed mostly of counselors and other mental health professionals who work in private practice, schools, colleges, community agencies, hospitals, and government. This journal is an appropriate outlet for articles that (a) critically integrate published research, (b) examine current professional and scientific issues, (c) report research that has particular relevance to professional counselor, (d) report new techniques or innovative programs and practices, and (e) examine LCA as an organization.

**MANUSCRIPT CATEGORIES**

Manuscripts must be scholarly, based on existing literature, and include implications for practice. The following categories describe the nature of submitted manuscripts. However, manuscripts that do not fall into one of these categories may also be appropriate for publication. These categories were adapted from the American Counseling Association’s *Journal of Counseling and Development (JCD)*.

1. **Conceptual pieces.** New theoretical perspectives may be presented concerning a particular counseling issue, or existing bodies of knowledge may be integrated in innovative ways.
2. **Research studies.** Both quantitative and qualitative studies are published in *LJC*. The review of the literature should provide the context and need for the study, followed by the purpose for the study and the research questions. The methodology should include a full description of the participants, variables, and instruments used to measure them, data analyses, and results. The discussion section includes conclusions and implications for future research and counseling practice.
3. **Practice articles.** Innovative counseling approaches, counseling programs, ethical issues, and training and supervision practices may be presented. Manuscripts must be grounded in counseling or educational theory and empirical knowledge.
4. **Assessment and Diagnosis.** Focus is given to broad assessment and diagnosis issues that impact counselors.

**MANUSCRIPT REQUIREMENTS**

##### All manuscripts must adhere to the guidelines set forth in the *Publication Manual of the American Psychological Association (6th ed.)*. The APA *Publication Manual* sets forth all guidelines concerning manuscript format, abstract, citations and references, tables and figures, graphs, illustrations, and drawings. Special attention should be given to the guidelines regarding the use of nondiscriminatory language when referring to gender, sexual orientations, racial and ethnic identity, disabilities, and age. Also, the terms “counselor” and “counseling” are preferred to “therapist” and “therapy.”

1. Submit an emailed, electronic, blind copy in Word of the entire manuscript to Meredith Nelson, mnelson@lsus.edu, Psychology Dept., One University Place, Shreveport, LA 71115 or three (3) clean, hard copies of the entire manuscript with an electronic version to Peter Emerson, *LJC* Editor, pemerson@selu.edu, SLU Box 10863, Hammond, LA, 70402.
2. Include a cover letter with your manuscript submission that contains your name and title, place of employment and position, address, telephone number, and e-mail address.
3. Manuscripts should not exceed 18 pages, including references.
4. Lengthy quotations (330-500 words) require written permission from the copyright holder for reproduction. Adaptation of tables and figures also requires reproduction approval. It is the author’s responsibility to secure this permission and present it to the *LJC* editor at the time of manuscript submission.
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7. Material that has been published or is currently under consideration by another periodical should not be submitted.
8. Generally, authors can expect a publication decision within 3 months after the acknowledgment of receipt.
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##### guidelines will be returned without review.